TARGETED PREVENTION ACTIVITY SHORT FORM

Intervention Name: _____ **Date:** ☐☐☐☐☐☐ *(mm/dd/yy)*

Provider's ID: ☐☐☐☐ **LHJ/Agency #:** ☐☐☐☐ **Location #:** ☐☐☐☐

Time of encounter: ☐☐ : ☐☐ ☐ AM ☐ PM *(hh/mm)* **Length of contact:** ☐☐☐ *(minutes)*

Testing Referral: *(mark one "x")*

- ☐ Tested at encounter →
- ☐ Referred for testing
- ☐ Declined/refused
- ☐ No testing referral

Unique Office of AIDS Number

Materials Distributed: *(mark all that apply "x")*

- ☐ Male Condoms
- ☐ Female Condoms
- ☐ Safer Sex Kits
- ☐ Bleach or Safer Injection Kits
- ☐ Referral List
- ☐ Education Materials
- ☐ Role Model Stories
- ☐ Needle Exchange
- ☐ Incentive
- ☐ None

Referrals: *(mark all that apply "x")*

- ☐ No referrals provided

Risk/harm reduction

- ☐ Comprehensive risk counseling (CRCS)
- ☐ HIV education & prevention services
- ☐ Perinatal care

Positive referrals

- ☐ HIV medical care
- ☐ HCV medical services
- ☐ HIV case management

Substance use services

- ☐ Alcohol/drug treatment
- ☐ Syringe exchange program

Other referrals

- ☐ Hepatitis testing/vaccination
- ☐ STD testing & treatment
- ☐ TB testing & treatment
- ☐ Reproductive health services
- ☐ Non-HIV/HCV medical services
- ☐ Social services

First letter of last name: ☐ **Date of birth:** ☐☐☐☐☐☐ *(mm/dd/yy)*

Residence zip code: ☐☐☐☐☐ **Mark if you live outside California:** ☐

Currently Homeless? ☐ Yes ☐ No ☐ D/R

Incarcerated in past 12 months? ☐ Yes ☐ No ☐ D/R

California county of residence: _____

Gender identity: *(mark one "x")*

- ☐ Male
- ☐ Female (indicate if pregnant & in care)
  - Pregnant? ☐ Yes ☐ No ☐ CDK
  - If yes, in perinatal care? ☐ Yes ☐ No
- ☐ Transgendered: M to F
- ☐ Transgendered: F to M

Race/ethnicity: *(mark all that apply "x")*

- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Hispanic/Latino(a)
- ☐ White

Sexual orientation: *(mark one "x")*

- ☐ Heterosexual or straight
- ☐ Bisexual
- ☐ Gay, Lesbian, Queer, Homosexual
- ☐ Client declines to state

Gender at birth: ☐ Male ☐ Female

Number of prior HIV tests: ☐☐ ☐ D/R
(enter zero if never tested before today)

Have you tested for HIV in the last 3 months? ☐ Yes ☐ No ☐ D/R

Date of last HIV test result received: ☐☐☐☐☐☐ *(mm/dd/yy)*

If you have tested before, what was the last test result you received? *(mark one "x")*

- ☐ Negative
- ☐ Positive *(indicate if in care)*
  - In HIV medical care/treatment? ☐ Yes ☐ No
- ☐ Preliminary positive *(no confirmatory result received by client)*
- ☐ Inconclusive, discordant, invalid
- ☐ Never have received a result

Gender of sex partner in last 12 months:

	Sexual activity *(partner's role)*			Condom use frequency:		
Male sex partner(s)						
# of partners (0-999): ☐☐☐	Oral Sex:	☐ Yes	☐ No			
	Vaginal receptive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
	Anal insertive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
	Anal receptive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
Female sex partner(s)						
# of partners (0-999): ☐☐☐	Oral Sex:	☐ Yes	☐ No			
	Vaginal receptive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
	Anal insertive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
Transgender sex partner(s)						
# of **male to female** partners (0-999): ☐☐☐	Oral Sex:	☐ Yes	☐ No			
	Vaginal insertive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
	Vaginal receptive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
# of **female to male** partners (0-999): ☐☐☐	Anal insertive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always
	Anal receptive:	☐ Yes	☐ No	☐ Never	☐ Sometimes	☐ Always

Sex partner type in last 12 months:

- **MSM** *(for female client)* ☐ Yes ☐ No
- **Sex worker partner(s)** ☐ Yes ☐ No
- **Partners who inject drugs** ☐ Yes ☐ No
- **HIV-positive partners** ☐ Yes ☐ No

Sex in exchange in last 12 months:

- **Received money or other items for sex** ☐ Yes ☐ No
- **Drugs for sex** ☐ Yes ☐ No

Substance use in last 12 months: ☐ No substance use

			If yes, was it injected?		
Methamphetamine	☐ Yes	☐ No	If yes, was it injected?	☐ Yes	☐ No
Cocaine	☐ Yes	☐ No	If yes, was it injected?	☐ Yes	☐ No
Crack	☐ Yes	☐ No	If yes, was it injected?	☐ Yes	☐ No
Heroin	☐ Yes	☐ No	If yes, was it injected?	☐ Yes	☐ No
Other, specify: _____	☐ Yes	☐ No	If yes, was it injected?	☐ Yes	☐ No

Injected hormones, steroids, vitamins, insulin, etc. and shared syringes/needles in last 12 months? ☐ Yes ☐ No

Have you ever used a needle to inject drugs? ☐ Yes ☐ No

STDs & Hepatitis: ☐ No STDS or Hepatitis in the last 12 months

	Last 12 months:		Lifetime:	
Syphilis	☐ Yes	☐ No	☐ Yes	☐ No
Gonorrhea or Chlamydia	☐ Yes	☐ No	☐ Yes	☐ No
Genital Herpes (HSV)	☐ Yes	☐ No	☐ Yes	☐ No
Human Papilloma Virus (HPV)	☐ Yes	☐ No	☐ Yes	☐ No
Hepatitis C (HCV)	☐ Yes	☐ No	☐ Yes	☐ No

Has a medical provider **ever** told you that you have Hepatitis C? ☐ Yes ☐ No

Data Entry Initials: ☐☐☐ **LEO Form #:** ☐☐☐☐☐